

Initial Care Plan

Revised Care Plan

Page 1 of 1

## INDIVIDUALIZED CLIENT CARE PLAN

Client Name: Suzy Que

14-Char Code: SZQE0101861XEM

Date: 1/1/09

PROBLEM		OBJECTIVE		
Client lacks sufficient income to secure and maintain stable housing.		Client will obtain assistance through available housing programs.		
KEY ACTION STEPS		PERSON RESPONSIBLE	TARGET DATE	COMPLETION DATE
1.	Client will apply for HOPWA services at AFH	Client	1/30/09	
2.	HCM will provide eligibility information to AFH	HCM	1/15/09	
3.	Client will apply for HUD Supportive Housing Program @ Agency Q	Client	1/31/09	
4.	HCM will provide eligibility information for Agency Q	HCM	1/15/09	
Outcome				

\_\_\_\_\_  
*Health Case Manager Signature/Name*

\_\_\_\_\_  
*Client/Guardian Signature/Date*

\_\_\_\_\_  
*Family/Significant Other Signature/Date*

HCM Service Level	
<input type="checkbox"/>	Intensive
<input type="checkbox"/>	Intermediate
<input type="checkbox"/>	Limited
<input type="checkbox"/>	Clinical Support

CLOSURE COMMENTS	

\_\_\_\_\_  
*Health Case Manager Signature/Name*

\_\_\_\_\_  
*Client/Guardian Signature/Date*

\_\_\_\_\_  
*Family/Significant Other Signature/Date*

Initial Care Plan

Revised Care Plan

### INDIVIDUALIZED CLIENT CARE PLAN

Client Name: Suzy Que

14-Char Code: SZQE0101861XEM

Date: 1/1/09

PROBLEM		OBJECTIVE		
Client lacks sufficient income to secure and maintain stable housing.		Client will obtain assistance through available housing programs.		
KEY ACTION STEPS		PERSON RESPONSIBLE	TARGET DATE	COMPLETION DATE
1.	Client will apply for HOPWA services at AFH	Client	1/30/09	NA
2.	HCM will provide eligibility information to AFH	HCM	1/15/09	1/13/09
3.	Client will apply for HUD Supportive Housing Program @ Agency Q	Client	1/31/09	1/29/09
4.	HCM will provide eligibility information for Agency Q	HCM	1/15/09	1/13/09
Outcome		Client obtained placement in the HUD SHP program at Agency Q		

\_\_\_\_\_  
Health Case Manager Signature/Name

\_\_\_\_\_  
Client/Guardian Signature/Date

\_\_\_\_\_  
Family/Significant Other Signature/Date

HCM Service Level	
<input type="checkbox"/>	Intensive
<input type="checkbox"/>	Intermediate
<input type="checkbox"/>	Limited
<input type="checkbox"/>	Clinical Support

#### CLOSURE COMMENTS

Identified Objective completed by client and health case manager. New care plan being developed to address additional objectives identified.

\_\_\_\_\_  
Health Case Manager Signature/Name

\_\_\_\_\_  
Client/Guardian Signature/Date

\_\_\_\_\_  
Family/Significant Other Signature/Date